DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33298

State File No.

Registration District No. Primary Registration District No. 1000 Registrar's No. 754

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2.2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 16 days (Specify whether years, months or days)
In this community: About 5-1 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 1823½ Frederick Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Ford Monroe Wasson
3. (b) If veteran, name war: No
3. (c) Social Security No. 491-09-7925
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mrs Chloe Wasson
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May (Month) 15 (Day) 1891 (Year)

8. AGE:

Years	Months	Days	If less than one day
5-1	5	19	hr. min.

9. Birthplace: St. Joseph (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Steam pipe fitter
11. Industry or business: Steam fitter
FATHER
12. Name: Edward Monroe Wasson
13. Birthplace: St Joseph (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name: Mrs Fred Becker
15. Birthplace: Iowa (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Chloe Wasson
(b) Address: 1823½ Frederick Ave. St. Joseph Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-5-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cem
18. (a) Signature of funeral director: Freeman & Son Inc
(b) Address: 1946 Calhoun
19. (a) 11-5-42 (Date received local registrar) (b) Rose Hayes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3 year 1942 hour 5:00 minute P. M.
21. I hereby certify that I attended the deceased from October 19, 1942, to November 3, 1942; that I last saw him alive on November 3, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Septic Meningitis	
Due to: Skull Fracture	5 Mos
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Sub-dural Hemorrhage	
Of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): Don't know
(b) Date of occurrence: 131
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: R B Sweany (M. D. or other)
Address: State Hosp - St Joseph Date signed: 11-4-42

1233 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9-4-41
5-17-39
PI X29484
11
1
7

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ .....

..... ~~Registered Apprentice No.~~ .....

~~working under my personal supervision.~~

Signed Robert L. Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33298

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 754

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joe (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ford Monroe Wasson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 15 (Day) 189 (Year)

8. AGE: Years 51 Months 5 Days 19 If less than one day or min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Septic meningitis

Due to skull fracture V 5 mos.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Sub-dural Hemorrhage

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence About September 15-1942

(c) Where did injury occur? St Joseph (City or town) Buchanan (County) Mo (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)

While at work? No (e) Means of injury Unknown

23. Signature R. T. Sweeney (M. D. or other)

Address State Hosp #2 St Joseph Mo Date signed 11-30-42

SUPPLEMENTARY